Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Fort Worth

Respondent Name
Poly America LP

MFDR Tracking Number
M4-15-0874-01

Carrier's Austin Representative
Box Number 11

MFDR Date Received
November 10, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am resubmitting the claim for payment for the following reasons: THIS IS NOT A DUPLICATE CLAIM/SERVICE. All other claims have been paid in full for this patient. I have presented same documentation to the carrier and they are still denying. Patient was approved for land and aqua based therapy with our office. Carrier shall not withdraw a preauthorization or concurrent review approval once issued. Clearly, they are wrong and all of my documentation states otherwise. Please see attached patient account statement showing all other claims being paid in a timely manner. I'm taking the next step to get the rest of these claims paid and sending all documentation I have to MDR. THESE ARE NOT DUPLICATES. All other claims have been paid at 100%. Therefore, these claims should be paid in full."

Amount in Dispute: $464.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on November 18, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 4, 2014	Physical Therapy (97140, 97112, 97113)	$464.31	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.203 sets out the fee schedule for billing and reimbursing professional medical services.
3. 28 Texas Administrative Code §133.210 sets out the medical documentation requirements for medical bills.
4. 28 Texas Administrative Code §133.240 sets out the procedures for denying or reimbursing medical bills.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - B1 – (B12) Services not documented in patients' medical records
   - 193 – Not defined as required in 28 Texas Administrative Code §133.240

Issues

1. Was the carrier's denial for lack of documentation appropriate?
2. Did the requestor support the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the disputed services, stating, "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication," and "Services not documented in patients' medical records." Documentation for physical therapy is not required with billing, according to 28 Texas Administrative Code §133.210 (b) or (c). 28 Texas Administrative Code §133.210 (d) states, "Any request by the insurance carrier for additional documentation to process a medical bill shall: (1) be in writing; (2) be specific to the bill or the bill's related episode of care; (3) describe with specificity the clinical and other information to be included in the response; (4) be relevant and necessary for the resolution of the bill; (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider; (6) indicate the specific reason for which the insurance carrier is requesting the information; and (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation."

   No documentation was found to support that the carrier made an appropriate request for additional documentation with the specificity required by §133.210(d). The Division concludes that carrier failed to meet the requirements of 28 Texas Administrative Code 133.210(d). The carrier's denial for this reason is not appropriate.
2. 28 Texas Administrative Code §133.307(c)(2) states in relevant part, "The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division…The request shall include: (M) a copy of all applicable medical records related to the dates of service in dispute."

   Further, 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Use of Medicare documentation requirements is appropriate to support of billed services.

   The Medicare Benefit Policy Manual, Chapter 15, §220.3.E. states, "Documentation of each treatment shall include the following required elements:

   - Date of treatment; and
   - Identification of each specific intervention/modality provided and billed, for both timed and untimed codes, in language that can be compared with the billing on the claim to verify correct coding…and;
   - Total timed code treatment minutes and total treatment time in minutes. Total treatment time includes the minutes for timed code treatment and untimed code treatment…and;
   - Signature and professional identification of the qualified professional who furnished or supervised the services and a list of each person who contributed to that treatment…"

   Further, the Medicare Claims Processing Manual, Chapter 5, §20.2.C. explains how time is counted and documented. Review of the submitted documentation finds that only 25 minutes of proprioception exercises were documented. Additionally, there is a signature present on the documentation, but it does not include the professional identification of the individual. Therefore, the Division finds that the documentation does not support the disputed services.
3. Because the requestor did not support the disputed services, no further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	April 7, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.